Brandon W. Romick, D.M.D. & Associates

Record Release Request

Date:_______________

To: ____

Address: ____

City: ____________________ State/Zip: ________________________

Phone: _______________________   Fax: _______________________

I request and authorize the release of dental records and x-rays relevant to dental treatment, or copies of such, and request they be transferred to: office@riversbenddental.com, if unable to transfer records via email please mail to the address below.

Patient's Name: _____________________________

Date of Birth: _______________________________

Signature: _________________________________

If patient is a minor, relationship to patient: _____________________

6270 River's Bend Drive, Maineville Ohio 45039 Ph: 513.494.0333 Fax: 513.494.0222